Adopted	Rejected

COMMITTEE REPORT

YES: 13
NO: 0

MR. SPEAKER:

Your Committee on ***Insurance, Corporations and Small Business*** *, to which was referred House Bill 1273 , has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill* ***be amended*** *as follows:*

Page 1, delete lines 1 through 17.

Delete pages 2 through 4.

Page 5, delete lines 1 through 11.

Page 7, line 17, delete "Sue" and insert "**Subject to section 2.6 of this chapter,** sue".

Page 8, between lines 13 and 14, begin a new line block indented and insert:

"**(15) Subject to section 3 of this chapter, negotiate reimbursement rates and enter into contracts with individual health care providers and health care provider groups.**".

Page 9, line 5, delete "The following may".

Page 9, delete lines 6 through 12.

Page 9, line 13, delete "Forty percent (40%)" and insert "**Thirty-five percent (35%)**".

Page 9, line 13, delete "and one hundred percent".

Page 9, line 14, delete "(100%) of the expenses of administration of the association".

Page 9, line 27, delete "Sixty percent (60%)" and insert "**Sixty-five percent (65%)**".

Page 9, line 27, delete "and one hundred".

Page 9, line 28, delete "percent (100%) of any loss described in subdivision (2)".

Page 9, line 29, delete "department of insurance" and insert "**auditor of state**".

Page 9, line 37, strike "Except".

Page 9, line 38, strike "as provided in sections 12 and 13 of this chapter,".

Page 9, line 38, delete "net" and insert "Net".

Page 11, line 1, delete "annually" and insert "**periodically**".

Page 11, line 1, delete "department of" and insert "**auditor of state**".

Page 11, line 2, delete "insurance".

Page 11, line 2, delete "sixty percent (60%)" and insert "**sixty-five percent (65%)**".

Page 11, line 3, delete "and one hundred percent (100%) of any loss described in".

Page 11, line 4, delete "subsection (g)(2),".

Page 11, line 4, delete ";" and insert "**.**".

Page 11, line 6, delete "department of insurance" and insert "**auditor of state**".

Page 11, line 7, delete "amount" and insert "**amounts**".

Page 11, line 24, after "2.3." insert "**(a)**".

Page 11, line 30, after "2.1" insert "**(as in effect December 31, 2004) or 2.4**".

Page 11, between lines 31 and 32, begin a new paragraph and insert:

"**(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December**

31, 2004) or 2.4 of this chapter as of the date of the report.

SECTION 4. IC 27-8-10-2.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2005]: **Sec. 2.4. (a) Beginning January 1, 2005, a member that, before January 1, 2005, has:**

(1) paid an assessment; and

(2) not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, in each calendar year beginning January 1, 2005, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each calendar year.".

Page 11, line 32, delete "IC 27-8-10-2.4" and insert "IC 27-8-10-2.5".

Page 11, line 34, delete "2.4." and insert "**2.5.**".

Page 11, line 41, delete "IC 27-8-10-2.5" and insert "IC 27-8-10-2.6".

Page 11, line 42, delete "JULY" and insert "JANUARY".

Page 12, line 1, delete "2004]: Sec. 2.5." and insert "2004 (RETROACTIVE)]: **Sec. 2.6.**".

Page 12, line 17, after "(d)" insert "**The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the appeal.**

(e)".

Page 12, delete lines 19 through 42, begin a new paragraph and insert:

"**(f) If a member sues the association, the court shall not award to the member:**

(1) attorney's fees or costs; or

(2) punitive damages.

SECTION 7. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 15, 2004 (RETROACTIVE)]: Sec. 3. (a) An association policy issued under this chapter may pay **an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy may be based on the association's** usual and customary ~~charges~~ **fee schedule** or ~~use other~~ **another** reimbursement ~~systems that are consistent with managed care plans, including fixed fee schedules and capitated reimbursement, for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter.~~ **method or combination of reimbursement methods established by the board of directors. However, if the association adopts a fee schedule based on Medicare reimbursement, the fee schedule must provide for a reimbursement rate for inpatient and physician service eligible expenses of not less than the Medicare reimbursement rate for the eligible expenses plus eight and one-half percent (8.5%).** Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during

the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

(b) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(c) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

(d) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(e) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

(f) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(g) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

(h) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

SECTION 8. IC 27-8-10-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:**

(A) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(B) any copayment, deductible, or coinsurance amounts applicable under the association policy.".

Delete pages 13 through 14.

Page 15, delete lines 1 through 9.

Page 15, delete lines 31 through 42, begin a new paragraph and insert:

"SECTION 10. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2004]: IC 27-8-10-12; IC 27-8-10-13.".

Page 16, delete lines 1 through 10.

Renumber all SECTIONS consecutively.

(Reference is to HB 1273 as introduced.)

and when so amended that said bill do pass.

_____

Representative Fry